South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5675

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: ___ - ___ - _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Work Phone: ( ) - _____ Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) - _____

Check applicable claims and complete all blanks.

1. The employee sustained a compensable accidental injury to the _____ (part of the body) on _____ (date) in _____ (county), State of _____ (state) .
2. That the Second Injury Fund was put on notice of the claim on _____ (date) .
3. That the carrier concluded the disability claim by ☐ Award ☐ Agreement on _____ (date) .
4. That the subsequent injury combined with or was aggravated by the below-named permanent impairment under S.C. Code Section 42-9-40 (d):
   a. Listed Impairment – (1) – (33) _____
   b. (34) (a) _____
   c. (34) (b) _____
5. ☐ a. That the impairment preexisted;
   ☐ b. That the impairment was permanent; and
   ☐ c. That the impairment is a physical condition.
6. ☐ That the prior impairment combined with or was aggravated by the subsequent injury.
7. ☐ That the combination/aggravation substantially increased the liability of the carrier for: ☐ disability ☐ medical or ☐ both.
8. ☐ That the impairment was a hindrance or obstacle to employment or re-employment.
9. ☐ a. That the employer has knowledge of the prior impairment;
   ☐ b. That the impairment was unknown to the employee and the employer; or
   ☐ c. That the employee concealed the prior impairment from the employer.
10. ☐ That the subsequent injury would not have occurred "but for" the prior impairment.
11. That the above claim qualifies for reimbursement under S.C. Code Section 42-9-410 because:

_____

_____

_____

12. Other grounds for claim: _____

_____

_____

_____

_____ _____
Signature Date